

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295050		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2009	
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RENO				STREET ADDRESS, CITY, STATE, ZIP CODE 445 W. HOLCOMB LANE RENO, NV 89511			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an annual Medicare recertification survey conducted at your facility on 1/26/09 through 1/29/09. The census was 172 residents. The sample size was 28 residents. Complaint #NV00020738 was investigated. The complaint was substantiated with a deficiency cited (F309). The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.			F 000			
F 168 SS=D	<p>The following deficiencies were identified:</p> <p>483.10(g)(2) EXAMINATION OF SURVEY RESULTS</p> <p>A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to post state agency contact information for all residents and specifically for 1 of 28 residents (#26).</p> <p>Findings include:</p>			F 168			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 168	Continued From page 1 Resident #26 was admitted on 7/15/08, with diagnoses including fractured neck of femur, closed fracture of the phalanx, diabetes mellitus, and muscle weakness. Resident #26's record review revealed that the resident was admitted to the facility for rehabilitation for difficulty with mobility and walking related to her non-weight bearing status of the right lower extremity. She required a bedside commode for elimination. Resident #26 was interviewed and reported that the facility failed to provide a bedside commode for her to use in a timely manner. The resident further reported that she wanted to file a complaint against the facility, but was unaware that the state agency existed. Tour of the facility on 1/26/09, revealed no evidence that the state agency's contact information was posted. On 1/27/09 at 1:30 PM, the Director of Nurses was interviewed and reported that the state agency's information was not posted anywhere in the facility.	F 168			
F 281 SS=D	Cross-reference F 309 483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy and procedure review, the facility failed to ensure that	F 281			

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F 281	<p>Continued From page 2</p> <p>services were provided in accordance with facility policy and procedures and professional standards of quality for 2 of 28 residents (#3, #27).</p> <p>Findings include:</p> <p>Resident #3 had a gastrostomy tube for nutrition and medication administration. On 1/27/09 at 8:10 AM, a registered nurse (RN) was observed giving medications to Resident #3 via the gastrostomy tube. The RN was observed to stop the feeding, attach a syringe to the gastrostomy tube, and administer the medications via the syringe. The RN was not observed to check placement of the gastrostomy tube prior to the administration of medications.</p> <p>On 1/27/09 at 8:15 AM the RN was interviewed. She stated that she did not usually check placement of the gastrostomy tube prior to administering medications or tube feeding. She stated that she did not know that checking the placement was supposed to be done.</p> <p>On 1/27/09 at 9:00 AM, the Director of Nurses was interviewed. She stated that it was the facility policy to check placement of a gastrostomy tube prior to administering feeding formulas or medications.</p> <p>On 1/27/09, at 9:30 AM, the facility policy and procedure for "Feeding Tube - Instilling Medication" was reviewed. Per the procedure step 6: "Attach syringe to end of the tube and insert 20 cc of air. a. Check placement and patency by auscultation. b. If tube is not adequately placed, do not give the medication and do not flush with water, but</p>	F 281			

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F 281	<p>Continued From page 3</p> <p>adjust placement of feeding tube or insert a new one."</p> <p>Cross reference F 322</p> <p>Resident #27 had an order for Amiodarone 100 milligrams (mg) by mouth daily and to "hold if heart rate less than 60." On 1/27/09 at 8:00 AM, a RN was observed administering the medication during a medication pass. The RN checked the resident's heart rate (HR) and proceeded to administer the medication. The RN then documented a HR of 57 in the Medication Administration Record (MAR).</p> <p>On 1/27/09, the RN 14 was interviewed. She stated she always checked Resident # 27's HR, but gave the medication before she read the parameters for holding the medication. The RN stated she only documented the HR on the MAR if it was below 60.</p> <p>Review of Resident #27's MAR for the month of December 20008 revealed no HR documentation listed on the MAR. Review of the MAR for January 2009 revealed one HR recorded on 1/17/09 of 53 and "hold" was written on the MAR.</p> <p>On 1/27/09, at 9:15 AM, an interview was conducted with the Director of Nurses. She stated "nursing should be recording the heart rate on the MAR each day per the physician order."</p> <p>Review of the facility policy and procedure for "Medication Administration" item 20 revealed that medications that require parameters are charted in the MAR.</p> <p>Cross reference F 329</p>	F 281			

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F 309 SS=D	<p>483.25 QUALITY OF CARE</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide necessary rehabilitation equipment in a timely manner for 1 of 28 residents (#26).</p> <p>Findings include:</p> <p>Resident #26 was admitted to the facility on 7/15/08 at 12:26 PM, with diagnoses including right trochanteric femur fracture with open reduction and internal fixation, and a closed fracture of the phalanx. The resident was admitted for intensive rehabilitation. The resident was 59 years old, alert and oriented.</p> <p>Resident #26's record review revealed an entry into the nurses notes dated 7/16/08 at 1:00 PM that read: "commode in room."</p> <p>Resident #26 was interviewed and reported that the facility failed to provide a bedside commode for her to use within the first day of her admission. She reported that her sister had purchased one for her to use in the facility. She reported that the facility did provide a commode on 7/16/08.</p> <p>Resident #26 further reported that she was told by facility staff to use a bedpan and that a</p>	F 309			

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F 309	Continued From page 5 bedside commode was not available. A registered nurse (RN) was interviewed on 1/26/09 at 1:00 PM, and reported that she recalled that Resident #26 "was not happy at the facility no matter what staff did to please her." She reported that she did not remember when the commode was placed in the resident's room. On 1/26/09 at 1:15 PM, a second RN was interviewed and reported that the bedside commode is usually placed in the resident's room "right away." He reported that a commode would be available at the facility and was kept in a storage area on the unit. He also reported that the facility staff often wait for the resident to have a physical therapy evaluation prior to providing any equipment. He also reported that the staff commonly offer a resident a bedpan if they have not had a physical therapy evaluation. He further reported that there was no written policy related to providing equipment in a timely manner. On 1/28/09 at 2:50 PM, the central supply clerk was interviewed and reported that the facility had bedside commodes stored on the units available for use. Review of the Resident #26's acute care facility record revealed that the nurses notes and case management notes referred to the need for, and the resident's use of, a bedside commode in numerous entries throughout the record. The physician's discharge summary dated 7/15/08, read: "At discharge, she is ambulatory."	F 309			
F 322 SS=D	Cross reference F 168 483.25(g)(2) NASO-GASTRIC TUBES	F 322			

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F 322	<p>Continued From page 6</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, the facility failed to ensure nursing checked the placement of a gastrostomy tube prior to administering medications for 1 of 28 residents (#3).</p> <p>Findings include:</p> <p>Resident #3 had a gastrostomy tube for nutrition and medication administration. On 1/27/09 at 8:10 AM, a registered nurse (RN) was observed giving medications to Resident #3 via the gastrostomy tube. The RN was observed to stop the feeding, attach a syringe to the gastrostomy tube, and administer the medications via the syringe. The RN was not observed to check placement of the gastrostomy tube prior to the administration of medications.</p> <p>On 1/27/09 at 8:15 AM the RN was interviewed. She stated that she did not usually check placement of the gastrostomy tube prior to administering medications or tube feeding. She stated that she did not know that checking the placement was supposed to be done.</p> <p>On 1/27/09 at 9:00 AM, the Director of Nurses</p>	F 322			

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F 322	Continued From page 7 was interviewed. She stated that it was the facility policy to check placement of a gastrostomy tube prior to administering feeding formulas or medications. On 1/27/09 at 9:30 AM, the facility policy and procedure for "Feeding Tube - Instilling Medication" was reviewed. Per the procedure step 6: "Attach syringe to end of the tube and insert 20 cc of air. a. Check placement and patency by auscultation. b. If tube is not adequately placed, do not give the medication and do not flush with water, but adjust placement of feeding tube or insert a new one."			F 322			
F 325 SS=D	Cross reference F 281 483.25(i) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that 1 of 28 residents maintained acceptable weight parameters (#11).			F 325			

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F 325	<p>Continued From page 8</p> <p>Findings include:</p> <p>Resident #11 was admitted to the facility 9/28/06 and readmitted on 10/31/07 with diagnoses including muscle weakness, Parkinson's disease, dementia, hypertension, anemia, hypothyroidism, and psychosis.</p> <p>A review of Resident #11's weight record revealed his admission weight on 10/31/07 was 156 pounds which was in his ideal body weight range of 139 to 169 pounds. The weight record revealed a progressive weight loss over the last year of 14.4 pounds. The resident was on monthly weights over the last year except for one month where his weight loss triggered intervention and weekly weights.</p> <p>The last full dietary assessment was dated 9/5/08. Resident #11's weight at that time was 147 pounds. The weight record indicated the resident weighed 138.9 pounds on 11/4/08, 136.4 pounds on 12/9/08, and 135.9 pounds on 1/5/09. There were no dietary progress notes from 6/3/08 to 1/5/09. The dietary progress note from 1/5/09 indicated the facility would add health shakes twice per day to Resident #11's dietary regimen.</p> <p>A review of the medical record indicated Resident #11 was found to have a scrotal wound on 12/3/08. Although the wound was healed within two weeks, the discovery of the wound did not prompt any dietary interventions.</p> <p>An interview with the dietician on 1/27/09 at 1:00 PM revealed there was no written criteria for placing a resident on weekly weights, and that the decision was a judgement call. When it was pointed out Resident #11 was still on monthly</p>	F 325			

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F 325	Continued From page 9 weights and was below his ideal body weight range for the last three months, the dietician agreed the resident should be on weekly weights. A review of the manual of "Nutrition Assessment and Documentation" supplied by the corporation, revealed a policy which stated residents who have a significant weight variance are evaluated and approaches are implemented per resident as needed. Under guidelines the policy stated residents with weight and/or intake concerns are evaluated according to the facility's guidelines. The dietician indicated there were no written facility guidelines for weight and intake management or criteria for determining timing of interventions.	F 325			
F 329 SS=D	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329			

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F 329	<p>Continued From page 10 drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that each resident's medication regimen was free of unnecessary drugs for 2 of 28 residents (#27, #16).</p> <p>Findings include:</p> <p>Resident #27 had an order for Amiodarone 100 milligrams (mg) by mouth daily and to "hold if heart rate less than 60." On 1/27/09 at 8:00 AM, a RN was observed administering the medication during a medication pass. The RN checked the resident's heart rate (HR) and proceeded to administer the medication. The RN then documented a HR of 57 in the Medication Administration Record (MAR).</p> <p>On 1/27/09, the RN 14 was interviewed. She stated she always checked Resident # 27's HR, but gave the medication before she read the parameters for holding the medication. The RN stated she only documented the HR on the MAR if it was below 60.</p> <p>Cross reference F 281 Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two cerebrovascular accidents and urinary tract infection.</p>	F 329			

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F 329	Continued From page 11 Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for a possible clostridium difficile (C-diff) infection. On 1/19/09, a stool culture was ordered. Resident #16's record review revealed that a lab report received by the facility on 1/20/09 at 2:00 PM, indicated that the resident did not have a C-diff infection. Further review of Resident #16's record revealed that the physician ordered the antibiotic to be discontinued on 1/26/09. The Resident Care Manager (RCM) was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because she was being treated with antibiotics with no indication.	F 329			
F 364 SS=B	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, the facility did not ensure its food was served at the proper temperature.	F 364			

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F 364	Continued From page 12 On 1/27/09 at 12:10 PM the following temperatures on a test tray were obtained at the Denton building kitchen, just after it had been placed on the cart to be delivered: barbecue beef -110 degrees Fahrenheit (F); baked beans -90 degrees F; coleslaw -52 degrees F; custard pie -50 degrees F. On 1/28/09 at 12:15 PM the following temperatures on a test tray were obtained at the Denton building: soup -122 degrees F; pork -120 degrees F; baked potato -130 degrees F; cooked cauliflower -110 degrees F; sour cream -50 degrees F. The soup was observed already poured in bowls with lids, sitting on the tray line, before the trays were assembled. The dietary manager stated that the kitchen's normal procedure was to put the soup in bowls at the time each tray was assembled. The dietary manager stated that the kitchen's policy was for hot food to be delivered at a temperature of at least 140 degrees F, and that cold food was to be delivered at a temperature of 40 degrees F or below. During the group interview on 1/28/09 at 10:00 AM, four residents stated that hot food was sometimes served colder than desired at the dining rooms. The guidelines developed by the corporate office stated that "Food temperatures are checked before serving; if issues are identified, they are corrected, or the food is discarded."	F 364			
F 371	483.35(i) SANITARY CONDITIONS	F 371			

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F 371 SS=B	<p>Continued From page 13</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, policy review and interview, the facility did not ensure food was stored and prepared under sanitary conditions.</p> <p>Findings include:</p> <p>An inspection of the facility's two kitchens on 1/26/09 revealed the following:</p> <p>Main kitchen - Refrigerator: a container of prepared ham au gratin was undated; opened bags of shredded mozzarella and cheddar cheese were undated. Equipment: scaling/yellowing was noted on the interior rim of the ice machine; food particles were present on the slicer even after regular sanitizing; the dish hood was soiled and moldy; the back surfaces of the oven and surrounding floor were soiled.</p> <p>Satellite (Denton) kitchen - Refrigerator: an opened bag of shredded mozzarella cheese was undated; an opened container of cottage cheese was undated; prepared ham and cheese sandwiches were undated. Freezer: an opened bag of meatballs was undated. Equipment: the</p>	F 371			

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F 371	Continued From page 14 dish hood was soiled and moldy.			F 371			
F 441 SS=E	<p>The dietary manager stated that the kitchen's policy was to date all leftovers and opened containers of potentially hazardous foods. The cold food storage guidelines developed by the facility's corporate office stated that "Leftovers are dated properly and discarded after 72 hours unless otherwise indicated."</p> <p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review the facility failed to follow up on residents with infections, or suspected infections, and the facility failed to establish an infection control program that investigated, controlled or prevented infections for 5 of 28 residents (#16, #20, #21, #22, #28).</p> <p>Findings include:</p> <p>Review of the facility's infection control log book revealed that the facility did not have a surveillance program to track or trend infections</p>			F 441			

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F 441	<p>Continued From page 15</p> <p>that are acquired in the facility. The "Infection Log" listed six nosocomial infections and two community acquired infections for the month of January. A document titled: "Line Listing of Patient Infections," listed 17 infections that were acquired in the facility in the month of January and one community acquired infection that did not meet the McGeer criteria.</p> <p>Research revealed that The Centers for Disease Control and Prevention (CDC) definitions for health care-associated infections (HAIs) were developed for hospitals and are generally not applicable to nursing homes. In 1991, McGeer et al developed a set of definitions for determining HAIs in long-term care. The criteria were developed by modifying the CDC definitions and taking into consideration the difference in population, services and resources. The criteria set forth was developed in accordance with the requirements of Act 52, using McGeer criteria and further modification of the CDC based criteria.</p> <p>On 1/28/09 at 3:30 PM, the Infection Control Nurse (ICN) was interviewed and reported that the facility only tracks community acquired infections and nosocomial infections which are defined as having met the McGeer criteria. She reported that any nosocomial infections that do not meet the McGeer criteria are not tracked or trended. She further reported that the facility does not discuss "other" infections in performance improvement meetings. She reported that the infections are treated but that no surveillance is done, and no measures are taken to control or prevent the spread of "other" infections.</p> <p>On 1/28/09 at 3:35 PM, the corporate nursing</p>			F 441			

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F 441	<p>Continued From page 16</p> <p>representative reported that the facility's infection control program should include tracking, trending, and steps toward control and prevention of all infections.</p> <p>Review of the facility's "Infection Control Program" book read: Chapter 1</p> <ul style="list-style-type: none"> -Goals of the Infection Control Program -Reduce acquisition and transmission of healthcare associated infections -Monitor for any occurrences of infection and implement appropriate control measures -Identify and correct problems relating to infection control practices -Ensure compliance with state, Federal, and OSHA regulations and JCAHO standards <p>Chapter 2 - Surveillance of Infections read: "Purpose - To have knowledge of resident and associate infections so appropriate actions/follow-up may guide prevention activities. Policy: The infection control nurse does surveillance of infections among residents and associates by:</p> <ul style="list-style-type: none"> -Reviewing culture reports and other pertinent lab data -Consulting with the nurses and referral -Reviewing charts -Reviewing infection control communication Form or 24 hour report -Following up on communicable disease exposure -Consulting with licensed independent practitioners <p>Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two</p>	F 441			

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F 441	<p>Continued From page 17</p> <p>cerebrovascular accidents and urinary tract infection.</p> <p>Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for a possible clostridium difficile (C-diff) infection. On 1/19/09, a stool culture was ordered.</p> <p>Resident #16's record review revealed that a lab report received by the facility on 1/20/09 at 2:00 PM, indicated that the resident did not have a C-diff infection.</p> <p>Further review of Resident #16's record revealed that the physician ordered the antibiotic to be discontinued on 1/26/09.</p> <p>Resident Care Manager (RCM) #4 was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because she was being treated with antibiotics with no indication. She further reported that she did not know why the lab report was missed. When asked what was the facility's policy related to physician notification of lab reports, she reported that the use of the communication book was not in a written policy, but that the nurses know that they are to use the book, or call the physician if necessary.</p> <p>Cross reference F511 Resident #22 was admitted to the facility on 1/21/09 with diagnoses that included</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>rehabilitation, difficulty in walking, muscle weakness, chronic osteomyelitis, diabetes mellitus, acute renal failure, and congestive heart failure.</p> <p>Resident #21 was admitted to the facility on 1/12/09 with diagnoses that included rehabilitation, difficulty in walking, muscle weakness, cerebrovascular accident, dysphagia, pneumonia, urinary tract infection, and staphylococcus aureus.</p> <p>On 1/26/09, the initial tour was completed on the 300 hall where Residents #21 and #22 lived. Resident #22 was observed to be in an infections precautions room, with a Stop sign advising visitors to report to the nursing station before entering. The RCM conducting the tour explained that Resident #21 in bed number two was in respiratory precautions for Methicillin resistant staphylococcal aureus (MRSA) in his sputum. He stated that the facility followed Center for Disease Control (CDC) recommendations for respiratory precautions. He stated that according to the CDC, as long as the curtain remained pulled and Resident #22 was not within three feet of the roommate, there was not a problem of transmission. He did not identify Resident #22 as having any acute infection.</p> <p>Review of Resident #22's medical record revealed a pre-admission billing diagnoses form completed by the sending facility that listed "MRSA, urine. Isolation?" Review of the laboratory tests revealed a wound culture done on 12/29/08 that was positive for MRSA. A nasal MRSA admission screen done on 12/31/08 was negative. Further review of laboratory testing for Resident #22 failed to reveal any other positive</p>	F 441			

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F 441	<p>Continued From page 19</p> <p>MRSA test.</p> <p>On 1/27/09, during the medication pass, the medication nurse identified that Resident #22 had MRSA of a wound on his foot.</p> <p>Resident #22's medical record was reviewed. Review of the nurses notes on 1/21/09, the resident was admitted to the room and had a Foley catheter intact upon admission. The nurse documented at 9:00 PM that Resident #22 was "on isolation for MRSA in urine." On 1/22/09, at 1:45 AM, a nurse documented that "isolation precautions maintained for MRSA in urine." On 1/27/09, a nurse documented that the resident had received an antibiotic "for MRSA to foot" without adverse effects. Review of the physician orders revealed Resident #22 was on Bactrim DS twice a day for chronic osteomyelitis. There was no medication ordered for a MRSA infection.</p> <p>Resident #21's medical record was reviewed and the discharge summary revealed the resident had nasal swabs that were positive for MRSA on 12/22/08. Review failed to reveal any additional testing for MRSA. Nursing documented on 1/13/09 the resident was on isolation precautions for MRSA in sputum. Review of the physician orders failed to reveal a medication ordered for a MRSA infection.</p> <p>On 1/28/09, the Infection Control Nurse was interviewed. Neither of these residents were on the infection control logs she kept. She explained there were two logs. One was for infections that were either nosocomial or community acquired. The second was for infections that the resident was being treated for but did not meet McGeer criteria for nosocomial infection. She explained</p>	F 441			

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F 441	<p>Continued From page 20</p> <p>that she was alerted to infections in the facility through either the telephone orders for antibiotics or the 24 hour report. She did not know why either Resident #21 or #22 was not listed on the infection control log. She further explained that a low-risk roommate would be one with no open wounds, no intravenous lines, and no tubes (gastrostomy tubes or Foley catheter, for example).</p> <p>On 1/29/09, Resident #22 was observed to have moved to another room. The resident stated that he had been moved the previous evening. Interview with the RCM, Employee #8, revealed that Resident #22 was determined not to have MRSA in his wound. The resident's wound had healed to a hard scab and unable to be cultured. Employee #8 did not know why nursing had identified the resident as having MRSA in the urine. He stated as far as he knew, Resident #22 did not have MRSA of the urine on admission.</p> <p>The facility's policy for MRSA precautions was reviewed and revealed the following under Room Arrangements: "It is preferable for residents with MRSA to be cohorted (share a room or be in a specific area with MRSA residents) or they may share a room with a low-risk roommate (intact skin and no invasive devices)."</p> <p>Resident #21 was identified as being positive for MRSA in his sputum. Resident #22 was admitted to the same room as Resident #21. Resident #21 had a Foley catheter intact upon admission. Review of the facility census at the time of Resident #21's admission revealed there were empty rooms available.</p>	F 441			

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F 441	<p>Continued From page 21</p> <p>Resident #20 was admitted to the facility on 3/21/08 with diagnoses that included muscle weakness, difficulty walking, cellulitis, hypertension, congestive heart failure, osteoarthritis, osteoporosis and hyperlipidemia.</p> <p>Review of Resident #20's medical record revealed a positive diagnosis of clostridium difficile (C-diff) on 1/25/09 and the resident was placed on Flagyl 250 milligrams every eight hours for seven days. The physician's progress note dated 1/26/09 documented " positive for urinary tract infection (UTI), positive for C-diff, and dehydration."</p> <p>On 1/27/08 an isolation cart was observed outside of Resident #20's room. No posting information was observed warning people to "stop" before entering the residents room. At 10:00 AM a certified nursing assistant (CNA) was observed in Resident #20's room without protective wear. At 1:00 PM visitors were observed in Resident #20's room without protective wear.</p> <p>An interview with a RN was conducted on 1/27/09 at 2:00 PM. She stated that Resident #20 was positive for C-diff and that "they gown up when doing any direct patient care, but otherwise it was okay to go into the room unprotected." It was observed that Resident #20 had a roommate. The RN was asked why Resident #20 had a roommate and the RN replied "we don't typically change resident rooms because Resident #20 is on bedrest."</p> <p>The RN and this surveyor put on protective wear and entered Resident #20's room. It was observed that there was no infectious waste</p>	F 441			

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F 441	<p>Continued From page 22</p> <p>receptacle inside the room and no signs of discarded protective gowns were observed anywhere in the room. The RN approached Resident #20's bed and the resident looked startled. The RN stated to Resident #20 "it's okay, we just put on all of the gear this time."</p> <p>Review of the facilities policy and procedure on Infection Control for Clostridium Difficile revealed the following contact precautions:</p> <ul style="list-style-type: none"> * Residents with diarrhea caused by C. difficile should be in private rooms or in the same room with other residents with C. difficile. If neither of the above rooming situations is available, review the specific resident situation to determine if a semi-private room with a low risk roommate is acceptable. * Gloves should be worn to enter the room of a resident who has diarrhea caused by C. difficile. * A gown is needed to enter the room of a resident who has diarrhea caused by C. difficile if substantial contact with the resident or environmental surfaces is anticipated. * Gowns and gloves should be removed before leaving the resident's room and hands must be washed immediately following hand hygiene guidelines. <p>An interview was conducted on 1/28/09 with the Director of Nursing (DON), Infection Control Nurse (ICN), and Corporate Nursing Representative to discuss the facility infectious control practices. The ICN stated that Resident #20's roommate was not moved because she was a "low risk" resident and Resident #20 was on bedrest. The facility resident census on 1/25/09 allowed for a private room for the infectious resident.</p>	F 441			

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F 441	<p>Continued From page 23</p> <p>Resident #28 was admitted to the facility on 10/5/07 with diagnoses including dermatitis/pruritis, cerebral vascular accident, muscle weakness, hypertension, depressive disorder, aphasia and speech disturbance.</p> <p>Review of Resident #28's medical record revealed a chronic history of dermatitis and pruritis with an order for Atarax 25 mg every 8 hours as needed for severe pruritus and Prednisone 10 mg every day. Resident #28 was diagnosed with a left jaw cellulitis on 11/25/08 and was treated with Keflex 500 mg every 8 hours for one week. On 1/5/09 Resident #28 was diagnosed with shingles and placed on Valtrex 1 gram three times daily for one week.</p> <p>Resident #28 was a roommate with a resident diagnosed positive for C. diff.</p> <p>An interview on 1/28/09 in the afternoon was conducted with the Director of Nurses, Infection Control Nurse (ICN), and Corporate Representative. The ICN stated Resident #28 was residing with another resident with a infectious disease because she was considered to be a "low risk" resident. The facility failed to provide what criteria they used to determine "low risk" but the ICN stated it was a resident "without any lines, tubes, or open skin." She stated "she did not feel Resident #28 was at increased risk based on these criteria."</p> <p>Review of the Infection Control Log revealed that neither the cellulitis or shingles infections were documented in the Log. The ICN stated "both infections must have been missed, but the two infections did meet the McGeer criteria and should have been entered into the log, tracked,</p>			F 441			

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F 441	Continued From page 24 and trended."			F 441			
F 511 SS=D	483.75(k)(2)(ii) RADIOLOGY AND OTHER DIAGNOSTIC SERVICES The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: Based on interview, record review and policy review the facility failed to notify the physician of a laboratory report in a timely manner for 1 of 28 residents (#16). Findings include: Resident #16 was admitted on 1/14/09, with diagnoses including lumbar laminectomy and fusion, lumbar spinal stenosis, history of two cerebrovascular accidents and urinary tract infection. Resident #16's record review revealed that an entry made in the nurses notes dated 1/18/09 at 1:00 AM, indicated that the resident had "multiple" episodes of diarrhea. Record review revealed that on 1/18/09, the resident had been started on an antibiotic for possible clostridium difficile infection. On 1/19/09, a stool culture was ordered. Resident #16's record review revealed that a lab report received on 1/20/09 at 2:00 PM, indicated that the resident did not have a clostridium difficile infection. Record review further revealed that the physician ordered the antibiotic to be discontinued on 1/26/09.			F 511			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 295050	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/29/2009
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF RENO			STREET ADDRESS, CITY, STATE, ZIP CODE 445 W. HOLCOMB LANE RENO, NV 89511		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 511	<p>Continued From page 25</p> <p>Resident care manager #4 was interviewed and reported that the lab report should have been placed in the "communication book" for the physician to review the following day. She reported that a nurse should have called the physician because Resident #16 was being treated with antibiotics with no indication. She further reported that she did not know why the lab report was missed. When asked what was the facility's policy related to physician notification of lab reports, she reported that the use of the communication book was not in a written policy, but that the nurses know that they are to use the book, or call the physician if necessary.</p> <p>Cross reference F 441</p>	F 511			